

Complete all forms and bring  
them with you on your scheduled  
appointment date.

*Thank you!*

*University Surgical Associates, PSC*

**General Surgery**

Robert N. Cacchione, M.D.  
William G. Cheadle, M.D.  
Glen A. Franklin, M.D.  
Richard N. Garrison, M.D.  
Brian G. Harbrecht, M.D.  
Farid J. Kehdy, M.D.  
Gerald M. Larson, M.D.  
Frank B. Miller, M.D.  
J. David Richardson, M.D.  
Jorge L. Rodriguez, M.D.  
Christopher R. Schneider, M.D.  
Jason W. Smith, M.D.  
Gary C. Vitale, M.D.

**Surgical Oncology**

Michael B. Flynn, M.D.  
Richard E. Goldstein, M.D., Ph.D.  
Robert C. G. Martin, M.D.  
Kelly M. McMasters, M.D., Ph.D.  
Hiram C. Polk, Jr., M.D.  
Amy R. Quillo, M.D.  
Charles R. Scoggins, M.D.

**Transplant**

Mary Eng, M.D.  
Christopher M. Jones, M.D.  
Michael R. Marvin, M.D.

**Colorectal Surgery**

Susan Galandiuk, M.D.  
Jeffrey R. Jorden, M.D.  
Michael H. McCafferty, M.D.

**Vascular Surgery**

Amit J. Dwivedi, M.D.  
Marvin E. Morris, M.D.  
Charles B. Ross, M.D.  
Andrea E. Yancey, M.D.

**Plastic and Reconstructive**

Larry D. Florman, M.D.  
Jarrod A. Little, M.D.  
Terry M. McCurry, M.D.  
Gordon R. Tobin, M.D.  
Bradon J. Wilhelmi, M.D.

**Otolaryngology,  
Head and Neck Surgery**

Jeffrey M. Bumpous, M.D.  
Swapna K. Chandran, M.D.  
Arun K. Gadre, M.D.  
Toni M. Ganzel, M.D.  
Kevin L. Potts, M.D.  
Welby Winstead, M.D.



Dear Patient:

Welcome to our ear, nose, and throat practice in association with University Surgical Associates! We are happy to serve you and glad you have chosen us. In order to make the most of your first visit to our practice we would ask that you help us with the following:

1. **Please bring copies of any pertinent physical examinations, laboratory or X-ray evaluations to the office with you.** If you have had these test done, our staff will be happy to help you locate and obtain them prior to your arrival.
2. **If you are participating in any of the following health plans or HMOs, please make sure that you have in hand the referral form from your primary care provider:**

Aetna HMO/Aetna MC/Aetna QPOS  
Cigna HMO/Cigna MC  
Humana HMO/Humana HMO-MBP  
Indiana Medicaid/Hoosier Healthwise  
Kentucky Medicaid/KENPAC  
Passport  
Tricare

**This is not an inclusive list; please check with your benefits administrator if you have any questions concerning referrals.**

If we can provide any assistance to you in these matters, or if you have any questions, please do not hesitate to give us a call at 502-583-3687.

Jeffrey M. Bumpous, M.D., F.A.C.S.  
Toni M. Ganzel, M.D., F.A.C.S.  
Arun K. Gadre, M.D.

Julie L. Goldman, M.D., F.A.C.S.  
Welby Winstead, M.D., F.A.C.S.

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. Please read the following policy. If you have any questions, please feel free to discuss them with our staff.

## **YOUR INSURANCE**

We have made prior arrangements with many insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required copayment at the time of service. The copayment will be collected when you arrive for your appointment. For elective surgery you will be contacted to arrange for payment of the coinsurance and deductible. In the event your health plan determines a service to be “not covered” or you have “no insurance coverage”, you will be responsible for the complete charge. We will also bill your health plan for all services we provide in the hospital. We will be glad to establish a payment plan to meet your needs.

## **MINOR PATIENTS**

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

## **CANCELLATION/NO SHOW POLICY**

An appointment must be cancelled 24 hours in advance. A patient that does not cancel their appointment at least 24 hours in advance or is a NO SHOW will be charged \$25.00.

## **SUPPLIES POLICY**

If we know there are supplies involved we will try to alert you of our charges before you come for your scheduled appointment. Your insurance may deny payment for this \_\_\_\_\_ service/supply. The patient/responsible party understand that this charge may be non covered and will be responsible for these charges at the time of service.

## **MEDICAL RECORD POLICY**

When requesting disability forms to be completed we will require a \$25.00 payment for the initial form and a \$10.00 payment for follow-up forms in advance of their completion.

## **PRESCRIPTION POLICY**

We ask that you call in your refill request for prescriptions during the hours of 9:00 am – 3:00 pm Monday thru Friday only. Prescription refills from 3:00 pm Friday – 9:00 am Monday are not available.

I have read and understand the financial policies of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

\_\_\_\_\_  
Signature of Patient or Responsible Party if a Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Co-responsible Party

\_\_\_\_\_  
Please Print the Name of the Patient



How did you hear about University Surgical Associates and/or your doctor?

- Internet       Radio       Direct Mail       Today's Woman       Louisville Magazine       Newspaper  
 Audience Playbill       Your physician       TV       Friend or word of mouth       Other \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Family Doctor / PCP: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

## Patient Information

Patient's Last Name:		First Name:		M.I.	Patient's Social Security #:	
Street Address:					Age:	Date of Birth:
City:		State:	Zip:	Email Address:		Patient's Home Phone:
Race:	Language:		Religion:		Patient's Cell Phone:	

[NOT NEEDED IF A CHILD]	Employment or Student Status (if not a minor):				Gender: (circle one)		Marital Status:	
	Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Active Military <input type="checkbox"/> Name of School: _____				Male Female		S M D W	
	Employment / Retirement Eff. Date: _____		Patient's Employer: _____				Patient's Occupation: _____	
	Patient's Work Phone & Ext#: _____		Employer's Address: _____				Date Employment Started: _____	
	Spouse's Date of Birth: _____		Spouse's Name: _____				Spouse's Social Security #: _____	
	Spouse's Work Phone: _____		Spouse's Employer: _____				Spouse's Occupation: _____	

## Responsible Party / Child's Parent Information

Responsible Party or Father's Name:				Responsible Party or Mother's Name:			
Social Security #:	Date of Birth:	Relationship to Patient:		Social Security #:	Date of Birth:	Relationship to Patient:	
Employer:		Work Phone & Ext:		Employer:		Work Phone & Ext:	
Home Address if different from Patient's: _____				Home Address if different from Patient's: _____			
City, State & Zip:		Phone:		City, State & Zip:		Phone:	

## Primary Insurance PLEASE NOTE: We MUST Make A Copy of Your Insurance Card.

Insurance Company Name:		Effective Date:	Subscriber's Date of Birth:
Subscriber's Full Name:		Subscriber's Social Sec #:	Relationship to Patient:

## Secondary Insurance PLEASE NOTE: We MUST Make A Copy of Your Insurance Card.

Insurance Company Name:		Effective Date:	Subscriber's Date of Birth:
Subscriber's Full Name:		Subscriber's Social Sec #:	Relationship to Patient:

## Emergency Contact SOMEONE WITH A DIFFERENT PHONE NUMBER

Name:	Phone Number:	Relationship to Patient:
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**RELEASE OF INFORMATION:** I hereby authorize the release of medical information or other information acquired during the course of examination and treatment to insurance carriers, physicians, or my legal representatives. I hereby request payment of benefits from all insurance carriers to University Surgical Associates P.S.C. I understand I am responsible for and will pay any amount not covered by insurance including collection costs and reasonable attorney fees if referred for collection.

\_\_\_\_\_  
Signature – Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
USA Doctor

\_\_\_\_\_  
Registrar

**UNIVERSITY SURGICAL ASSOCIATES, PSC PATIENT HISTORY FORM**  
(see also dictated note/letter from today's date)

**Patient's Name:** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

**Age:** \_\_\_\_ **Birth Date:** \_\_\_\_\_ **Race:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Family Physician: Dr.** \_\_\_\_\_ **Referred by: Dr.** \_\_\_\_\_

**Other Physicians you see:** \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_

**THIS BOX FOR MD USE ONLY**

Location  
Quality  
Severity  
Duration  
Timing  
Context  
Modifying Factors  
Associated Signs and Symptoms

**Past Medical Problems: (check boxes that apply, describe below and list dates if possible)**

High Blood Pressure    Diabetes    Heart Disease/Heart Attack    Kidney Disease    Lung Disease/COPD    Seizures    Stroke    Cancer    Emotional/Psychiatric Problems    Hepatitis

**List all Previous Operations/Procedures** (for example, colonoscopy, cardiac stent, etc.) List reason, date, & MD

**Cancer Treatments:** Have you ever had Chemotherapy or Radiation Therapy? If so when and by whom:

**Medications: (List name, dose, & how often taken)**

**Do you take aspirin/ aspirin-containing products / any blood thinners?**  YES  NO (if yes, please list)

**Are you allergic to any medications?**  YES  NO (if yes, please list) **ALLERGIC to LATEX?**  YES  NO

**Social History**

Single  Married  Separated  Divorced  Widowed Occupation \_\_\_\_\_  
 Do you use alcohol?  YES  NO How much and how often? \_\_\_\_\_  
 Do you use tobacco now?  YES  NO Did you ever use tobacco?  YES  NO  
 Describe tobacco use (for example, packs per day) \_\_\_\_\_  
 Heavy Sun Exposure in past?  YES  NO Blistering Sunburns in past?  YES  NO  
 Tanning Bed Use?  YES  NO

**Family History** List diseases (including specific types of cancer) that run in the family, which relative was affected, and at what approximate age.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ROS: List all symptoms that you are experiencing currently**

<u>General</u>	<u>Yes</u>	<u>No</u>	<u>Heart</u>	<u>Yes</u>	<u>No</u>	<u>Reproductive History</u>	<u>Yes</u>	<u>No</u>
Weakness	_____	_____	Chest Pain	_____	_____	Age at 1 <sup>st</sup> period	_____	_____ yrs
Weight loss	_____	_____	Heart Attack	_____	_____	Age at menopause	_____	_____ yrs
Fever/chills	_____	_____	Irregular Heart Beat	_____	_____	# Pregnancies	_____	_____
Night sweats	_____	_____	Heart Failure	_____	_____	# Live births	_____	_____
<u>Eyes</u>	<u>Yes</u>	<u>No</u>	Swelling in Ankles	_____	_____	Age at 1 <sup>st</sup> pregnancy	_____	_____ yrs
Vision changes	_____	_____	Palpitations	_____	_____	Breast Fed	_____	_____
Double vision	_____	_____	<u>Gastrointestinal</u>	<u>Yes</u>	<u>No</u>	If yes, your age at the time	_____	_____ yrs
<u>Head/Neck</u>	<u>Yes</u>	<u>No</u>	Abdominal pain	_____	_____	Last Menstrual period	_____	_____
Headache	_____	_____	Nausea/Vomiting	_____	_____	Last Pap Smear	_____	_____
Blackout spells	_____	_____	Vomit Blood	_____	_____	Currently use Hormone	_____	_____
Changes in hearing	_____	_____	Difficulty Swallowing	_____	_____	Replacement Therapy	_____	_____
Changes in taste/smell	_____	_____	Heartburn /Indigestion	_____	_____	If yes, how long	_____	_____
Thyroid Problems	_____	_____	Blood in Stool	_____	_____	Previously used Hormone	_____	_____
Neck lumps	_____	_____	Black/Tarry Stool	_____	_____	Replacement Therapy	_____	_____
Ear pain	_____	_____	Change in stool size/color	_____	_____	If yes, when stopped	_____	_____
<u>Hematologic</u>	<u>Yes</u>	<u>No</u>	Constipation	_____	_____	<u>Neurologic</u>	<u>Yes</u>	<u>No</u>
Anemia	_____	_____	Yellow Jaundice	_____	_____	Tingling	_____	_____
Easy Bruising	_____	_____	<u>Kidney</u>	<u>Yes</u>	<u>No</u>	Numbness	_____	_____
Clotting Problem	_____	_____	Blood in Urine	_____	_____	Weakness	_____	_____
<u>Lung</u>	<u>Yes</u>	<u>No</u>	Kidney/bladder infection	_____	_____	<u>Psychiatric</u>	<u>Yes</u>	<u>No</u>
Lung problems	_____	_____	Kidney stones	_____	_____	Depression	_____	_____
Shortness of breath	_____	_____	Painful urination	_____	_____	Anxiety	_____	_____
Cough up blood	_____	_____	Difficulty urinating	_____	_____	Mood swings	_____	_____
Wheezing/Asthma	_____	_____	<u>Breast</u>	<u>Yes</u>	<u>No</u>	<u>Skin</u>	<u>Yes</u>	<u>No</u>
Pneumonia	_____	_____	Lump	_____	_____	Rash	_____	_____
Tuberculosis	_____	_____	Nipple discharge	_____	_____	Skin cancer	_____	_____
<u>Musculoskeletal</u>	<u>Yes</u>	<u>No</u>	Pain	_____	_____	Change in mole	_____	_____
New aches/pains in	_____	_____	Date Last Mammogram	_____	_____			
Bones/joints	_____	_____						
Arthritis	_____	_____						

**FOR BARIATRIC PATIENTS ONLY:**

Diets used and weight lost: \_\_\_\_\_  
 Sustained weight loss: \_\_\_\_\_ How long was weight lost? \_\_\_\_\_  
 How long over 100 lbs. overweight? \_\_\_\_\_ How many times have you lost over 25 lbs? \_\_\_\_\_  
 How long have you been overweight? \_\_\_\_\_ years.  
 Are you currently under a physician's care for weight loss? YES NO Physician's Name: \_\_\_\_\_

**PHYSICIAN COMMENTS:**

\_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

(History Form Reviewed with Patient)

**University Surgical Associates, PSC  
401 East Chestnut Street Suite 710  
Louisville, Ky 40202**

**Dear Patient,**

In order to help us stay within the guidelines of HIPAA, please list below any person /persons that you authorize us to disclose information to regarding your Protected Health Information. **(You do not need to list any of your doctors.)**

<b>Name</b>	<b>Relationship</b>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Do we have your permission to leave information on your **answering machine** when you are not at home?

**Yes** \_\_\_\_\_ **No** \_\_\_\_\_

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient's (or Guardian's) Signature

\_\_\_\_\_  
Date



## **Did you know that your surgeon not only takes care of patients, but:**

- Is a Professor of Surgery at the University of Louisville School of Medicine?
- Performs basic, translational, and clinical research to improve patient care?
- Teaches students, residents and fellows who come from around the world to learn the latest surgical procedures and participate in groundbreaking research?

We want to tell you about some of the exciting research and educational programs that are underway in the Department of Surgery at the University of Louisville School of Medicine. We are proud to be nationally recognized for groundbreaking advances in: **Cancer Detection and Treatment, Trauma and Critical Care, Minimally Invasive Surgery, Bariatric Surgery, Digestive Diseases, Endocrine Surgery, Vascular Surgery, Head and Neck Surgery, Plastic and Reconstructive Surgery, Hearing and Speech Disorders, Organ Transplantation, and Surgical Infections.**

A small sampling of our research includes:

1. The Sunbelt Melanoma Trial, a multicenter study that is the largest ever conducted in melanoma with more than 3,600 patients registered. It was conceived, written and directed from the Department of Surgery.
2. Genetic research relating to colorectal cancer and inflammatory bowel disease, which together affect hundreds of thousands of Americans every year. We have been using the latest technology such as gene chips to try to identify the cause of these disorders.
3. Minimally Invasive Parathyroid and Thyroid Surgery. We are one of the first centers to develop and test the procedure of Minimally Invasive Radioguided Parathyroidectomy, which allows patients with parathyroid tumors to undergo a much less invasive yet curative procedure through a small incision. We have also developed techniques for minimally invasive endoscopic thyroid surgery.
4. Studies of sound perception and speech production in children and adults that have undergone cochlear implant surgery
5. The University of Louisville Breast Cancer Sentinel Lymph Node Study, which involves more than 4,000 patients from 79 institutions across the US and Canada. It is the largest study of its kind and is largely responsible for the acceptance of this minimally invasive procedure for patients with breast cancer around the world.



6. Basic research into the molecular basis for the response to trauma, shock, inflammation, and infection.
7. New technologies for the treatment of liver tumors. Over the past decade, we have helped develop and test new minimally invasive techniques for treatment of liver tumors. This allows many patients who previously were not candidates for surgery to eliminate cancer in the liver.
8. New gene therapy approaches to cancer as an alternative to chemotherapy. In the past decade, we have developed several new treatments of liver tumors, colon cancer, pancreatic and stomach cancer, melanoma, breast cancer, and cervical cancer.
9. Studies to evaluate rare endocrine tumors using artificial intelligence.
10. We were one of the first U.S. centers to pioneer the use of the Lap Band System™ and other minimally invasive surgical treatments for obesity. We were the first center in America to perform an intragastric balloon and this was done in the setting of a clinical trial.

### **This is where you can help.**

Research is responsible for the development of new approaches to surgery and the treatment of a variety of conditions and diseases. We have made much progress, yet our work is far from done. With additional funding support, we feel confident we can bring some of these exciting results to our patients more quickly.

Your investment in our research will bear dividends for years to come, helping others facing a diagnosis such as yours. Any amount helps, and you can specify where you would like your money to be used.

If you are interested in investing in our research by making a donation or want to learn more, please contact Lukas C. Dwelly, MPA, MA by email at [lukas.dwelly@louisville.edu](mailto:lukas.dwelly@louisville.edu) or **502-235-1002**. He also may contact you following your treatment to gauge your interest and to discuss your experience with our office. In addition, you can discuss your interest with your surgeon or our office staff any time. You can also visit our Web site at [louisvillesurgery.com](http://louisvillesurgery.com). Thank you again for your confidence in our program.

*If you wish to have your name removed from the list to receive fundraising requests supporting the Department of Surgery, please make your wishes known in writing to: Department of Surgery, Development Office, 530 South Jackson Street; Louisville, KY 40202, and all reasonable efforts will be taken to ensure you will not receive any such communications from us in the future.*